Adopted November 21, 1997 by the Managed Health Care Improvement Task Force

IMPACT OF MANAGED CARE ON QUALITY, ACCESS AND COST FINDINGS

I. INTRODUCTION

Early signs of managed care have existed in California for decades. However, managed care has grown faster and farther in recent years, causing rapid change in the areas of quality, access, and cost.

II. IMPACT OF MANAGED CARE ON QUALITY

Quality has been defined variously by different individuals and organizations.[1] Some define quality in terms of the outcomes that quality care should efficiently and effectively provide. Others have simply defined quality as "doing the right thing right." Though not current and not entirely specific to California and therefore difficult to draw conclusions from with certainty, the best scientifically valid and available evidence suggests that health maintenance organizations (HMOs) have improved quality in several areas, but that there are also some areas of concern. Patients and providers (e.g., physicians and other appropriately licensed health professionals operating within their scope of practice) alike are concerned that certain aspects of quality have suffered as a result of managed care.

According to available research, there is no "winner" between HMOs and traditional, unmanaged, fee-for-service "indemnity" plans. Certain empirical studies have demonstrated that quality of care under HMOs is often found to be the same or better; others suggest that care has been worse.[2] In addition, managed care and indemnity are not monoliths. Each consists of high, medium, and low quality organizations and individual providers. Nor should the results of studies related to HMOs be generalized to all forms of managed care, which include preferred provider organizations that often have much in common with indemnity plans. Several studies point to specific areas of quality concerns in HMOs including the chronically ill elderly and chronically ill poor,[3] shorter lengths of stay,[4] and detection and treatment of mental health.[5,6] Most studies of customer satisfaction of the insured adult population conclude that Americans are generally satisfied with their health care coverage and the quality of their care, regardless of type of plan.[7,8,9,10] However, there is variation in satisfaction among plans within plan model types, and for some populations and some measures satisfaction is lower (See also Task Force paper on Public Perception and Experiences with Managed Care).

Several quality-enhancing activities are associated with the best practices of managed care. They include quality measurement, quality improvement, process improvement, provider profiling and publishing

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[1] Blumenthal D, "Part 1: Quality of Care–What Is It?," *The New England Journal of Medicine*, 335:12, September 19, 1996, 891-4.

[2] Miller R and Luft H, "Does Managed Care Lead to Better or Worse Quality of Care?," *Health Affairs*, 16:5, September/October 1997, 7-25.

[3] Ware J, et al., "Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems: Results From the Medical Outcomes Study," *JAMA*, 276:13, October 2, 1996, 1039-47.

[4] Gazmararian J, Koplan J, "Length-Of-Stay After Delivery: Managed Care Versus Fee-For-Service," *Health Affairs*, 15:4, Winter 1996, 74-80.

[5] Wells K, Sturm R, "Care for Depression in a Changing Environment," *Health Affairs*, 14:3, Fall 1995, 78-89.

[6] Wells K, Hays R, Burnam M, Rogers W, Greenfield S, Ware J, "Detection of Depressive Disorder for Patients Receiving Prepaid or Fee-for-Service Care: Results From the Medical Outcomes Study," *JAMA*, 262:23, December 15, 1989, 3298-3302.

[7] Donelan K, "What Patients *Really* Think of Managed Care," *Managed Care*, February 1996, 17-24.

[8] "Public Opinion of Health Plans Up," Health Market, September 29, 1997, XIV:15, p.1.

[9] Pacific Business Group on Health (PBGH), *California Consumer HealthScope*, 1997.

[10] "Health Care in California", Study #361, *Los Angeles Times*, June 1995.

provider outcomes measures, continuity and coordination of care, disease management, prevention and health promotion, early diagnosis, reduction in treatment variation, concentration of volume sensitive procedures in high volume centers, and rewarding quality. Many of these activities have been driven by purchasers and not the organizations themselves. Not all managed care organizations have embraced them or embraced them all. None of these activities are sufficient in and of themselves, but must work together with other elements to improve quality.

III. IMPACT OF MANAGED CARE ON ACCESS

Access is a multi-faceted issue, and the story of access under managed care is one of trade-offs. HMOs have generally improved financial access to insurance and care. Lower HMO premiums keep coverage more affordable for more people.[11] Modest copayments and no deductibles make care at the point-of-service for those covered generally more affordable. In addition, HMOs provide access to certain benefits, such as prevention and health promotion, which were not typically covered benefits in unmanaged products.

Despite lower overall costs generally, the number of uninsured continues to be high. Despite the lower proportion of total health care costs born by consumers, some consumers perceive their costs going up because their employers have shifted responsibility for additional costs to them directly.[12] In fact, employer-paid benefits come out of employees' total compensation, at least in the long-run, but this is an economic principle that consumers do not generally recognize.[13] While employee out-of-pocket costs have increased, these cost increases would likely have been greater in the absence of managed care.

The flip-side of greater financial access is tighter restrictions on access to providers and services. Because HMOs require lower cost-sharing in general than non-HMOs, demand for services increases, requiring HMOs to restrict services based on need in order to control costs. Closed-end HMOs restrict choice of providers to those within their networks. At-risk HMOs and their contracted medical groups and IPAs also apply greater restrictions on access to providers and services as they attempt to manage utilization and prevent unnecessary care. According to some, additional access concerns under managed care include formulary restrictions,[14] mental health services restrictions,[15] and lack of insurance coverage in rural areas.[16,17] Enrollees of managed care plans, especially vulnerable populations, also report greater unmet medical needs than in unmanaged plans.[18,19,20]

IV. IMPACT OF MANAGED CARE ON COST

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[11] Shiels J and Haught R, "Managed Care Savings for Employers and Households: Impact on the Number of Uninsured," study for the American Association of Health Plans, June 18, 1997.
[12] Tannenbaum J, "Health Costs at Small and Midsize Firms Decline," *The Wall Street Journal*, September 11, 1997, B2.
[13] Fuchs V, "It's Not Employers Who Bear the Costs," *Los Angeles Times*, September 21, 1993, B7.
[14] "Joint Oversight Hearing on the Regulation of Pharmaceutical Benefit Managers (PBMs): Current Trends, Future Options," Senate Committee on Insurance and Conference Committee on AB 1136, February 7, 1996; and Keating P, "Why You May Be Getting The Wrong Medicine," *Money*, June 1997, 142-57.
[15] Boyle P and Callahan D, "Managed Care and Mental Health: The Ethical Issues," *Health Affairs*, 14:3, Fall 1995, 7-22.
[16] Ricketts T, Slifkin R, Johnson-Webb K, "Patterns of Health Maintenance Organization Service Areas in Rural Counties," *Health Care Financing Review*, 17:1, Fall 1995, 99-113.
[17] Serrato C, Brown R, Bergeron J, "Why Do So Few HMOs Offer Medicare Risk Plans in Rural Areas?" *Health Care Financing Review*, 17:1, Fall 1995, 85-97.
[18] Mark T, Mueller C, "Access To Care In HMOs And Traditional Insurance Plans," *Health Affairs*, 15:4, Winter 1996, 81-7.
[19] Donelan K, Blendon R, et al., "All Payer, Single Payer, Managed Care, No Payer: Patients' Perspectives in Three Nations," *Health Affairs*, 15:2, Summer 1996, 254-65.
[20] Nelson L, et al., "Access To Care In Medicare HMOs, 1996," *Health Affairs*, 16:2, March/April 1997, 148-56.

Driven by purchasers, competition, and threat of legislation, managed care has slowed the rise in health insurance costs.[21] Nationally, costs of employer-sponsored premiums increased by 11.5% overall in 1991. Increases fell steadily to a 0.5% increase in 1996, with a slight upturn in 1997 to a 2.1% increase, about the rate of inflation.[22] Recent reports suggest that premium prices are expected to increase more in 1998, though less so in California than elsewhere.[23]

According to HMO self-reported data, average premiums in California increased for families by 17.3% and 6.6% for individuals in 1992 (See Background Paper, Figure 1).[24] Since then, premiums have increased at a much lower rate or decreased through 1996. Since 1992, year-to-year changes in average premiums have been better than the national average (See Background Paper, Figure 1). In addition, with increased managed care enrollment, all sectors in California for which data is available also show reductions in the rate of premium growth (See Background Paper, Figures 2-5).

A 1997 study by The Lewin Group estimated the amount of savings resulting from managed care.[25] Based on their own and more conservative Congressional Budget Office assumptions, the Lewin Group found that total national savings attributable to managed care in 1996 was between $23.8 and $37.4 billion. Total savings over the 1990 to 1996 period were between $116 and $181 billion. For California, savings in 1996 were between $5.5 and $8.6 billion or between 15% and 23% of total premiums. Total savings over the 1990 to 1996 period were between $28.4 and $44.3 billion.

Information about the cost structure underlying insurance premiums suggests that California generally has a lower cost structure than the nation on average (See Background Paper, Figure 6). Variations in utilization of hospital days and visits among California medical groups may suggest continued room for improvement. According to medical group data, the least efficient medical group typically uses twice the resources of the most efficient medical group (See Background Paper, Figure 6).[26] Improvement in the least efficient groups could reduce costs considerably. Further improvement, however, may not be easy. Efforts such as fall prevention and disease management require sophisticated team-based care management that is not well-developed in all HMOs or model types.

Managed care may also impact important non-economic factors such as uncompensated care and emerging clinical research which should also be considered in an evaluation of impact on costs. However, no empirical evidence is available in these areas.

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[21] Congressional Budget Office, "Trends in Health Care Spending by the Private Sector," April 1997.
[22] *Health Benefits in 1997*, KPMG Peat Marwick LLP, October 1996, Tysons Corner, VA.
[23] Kilborn P, "Analysts Expect Health Premiums to Rise Sharply," *The New York Times*, October 19, 1997, A1.
[24] Premiums are weighted by HMO size. Average premiums reported by HMOs include individuals and groups. California to national comparison does not account for differences in benefits packages, however, year to year changes provide some historical adjustment. Hoechst Marion Roussel, *HMO-PPO Digest*, 1992-1997.
[25] Sheils J and Haught R, "Managed Care Savings for Employers and Households: 1990 through 2000," *The Lewin Group*, prepared for the American Association of Health Plans, May 23, 1997.
[26] Analysis did not control for patient populations or for outcomes. The term "efficient" is intended to describe a group's use of resources, including number of days and office visits.